Illinois Department of PUBLIC HEALTH

NEWS RELEASE

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RECEIVER APPOINTED TO MANAGE EMERALD PARK HEALTH CARE CENTER

SPRINGFIELD, Ill. – At the request of the Illinois Department of Public Health and Attorney General Lisa Madigan, a new management team has been appointed by the Cook County Circuit Court to assume the day-to-day operations of Emerald Park Health Care Center in Evergreen Park, a 249-bed skilled and intermediate care facility.

Tuesday's court action was the result of an emergency motion filed April 27 by the Attorney General's office on the behalf of IDPH. Dr. Eric E. Whitaker, state public health director, and Madigan sought the receivership due to concerns about the health and safety of the residents at 9125 S. Pulaski Road in Evergreen Park. Representatives of Emerald Park agreed to the operation plan, which was signed today by Judge Julia Nowicki.

"I applaud Judge Nowicki's decision to appoint a temporary receiver to take over the management of this facility and to assess its operations," Dr. Whitaker said. "There has been a fundamental breakdown in the administration of Emerald Park, resulting in continued and escalating risk to residents of the facility and the surrounding community."

Dr. Whitaker and Madigan said that the court-appointed receiver, Pathway Health

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Services, assumed control of Emerald Park today. In addition to the operation and management of the facility, Pathway will assess the conditions at the facility and submit a written report of its observations, concerns and recommendations to the court by May 23, 2005.

"Pathway is immediately taking over operation of Emerald Park. Our goal is to ensure the health, safety and welfare of the residents of the facility and the surrounding community," Madigan said. "Pathway's report will help provide the court with a much-needed view of the inner workings of Emerald Park."

The Wisconsin-based company is currently providing monitoring services for the Department at Emerald Park. The Department assigned a monitor in February 2004 to regularly visit the facility to check on the welfare of the residents. On April 18, during a Department investigation, monitoring of the facility was increased to around the clock.

IDPH began proceedings to revoke Emerald Park's operating license in June 2004 and also fined the facility $10,000 for substantial failure to comply with the Nursing Home Care Act. A hearing on the matter is scheduled to begin July 18.

IDPH began revocation proceedings after learning the facility failed to provide adequate personal care and supervision to a resident who engaged in sexual activity with multiple partners in exchange for favors and cigarettes. The resident had a sexually transmitted disease (STD) and her sexual partners were not counseled about the possibility of acquiring an STD. The facility did not discover the resident was pregnant until she was at 32-weeks gestation and then failed to provide prenatal care.

After the most recent investigation at the facility concluded April 22, IDPH determined that multiple immediate jeopardy deficiencies existed at the facility. These include:

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- An employee took several residents on an outing to a local park, which was adjacent to a school. The employees did not get the list of residents going on the outing approved by administrative staff. At least one of the residents was a registered sex offender who should not have been allowed on the outing. The employee said the resident had been on several approved outing to the park.
- The facility failed to adequately assess the behavior and criminal backgrounds of residents to assure they can provide adequate supervision. The facility also failed to assure that a physical assessment was completed at the time of admission, which would have identified that two residents had Department of Corrections monitoring devices attached to their legs at the time of admission.
- Multiple fires were intentionally set at the facility during the weekend of April 16 to 17. There were no injuries, but staff's response was inadequate and it was a further indication of the facility's failure to supervise residents.

Other serious violations against Emerald Park include:

- A $20,000 fine for not providing nursing services in accordance with residents' needs following an October 2003 survey. The facility failed to properly monitor the health of a resident who passed out after becoming intoxicated, to report resident abuse, to prevent a resident from leaving the facility unnoticed and to provide special rehabilitative programs to mentally ill residents.

- A $5,000 fine for not protecting a resident from physical and mental abuse following a July 2002 survey. A resident was interrogated by a facility security guard who refused to let the resident leave the room, pushed the resident and put him in a police hold. The resident told surveyors that he had been interrogated and harassed by this security guard on other occasions and he had reported these to management.